STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155029	B. WING		04/07/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R	5600 E	AST 16TH STREET	
COMMUI	NITY NURSING AN	ID REHABILITATION CENTER	I	IAPOLIS, IN46218	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000		
	State Licensure	Survey.			
	Survey Dates: A	April 3, 4, 5, 6 & 7, 2011			
	·				
	Facility Number	:: 000012			
	Provider Numbe				
	Aim Number:	100274900			
		2002/ 1500			
	Survey Team:				
	Diana Zgonc RN	J TC			
	Connie Landma				
	Courtney Hamil				
	Christi Davidson				
	(April 4 & 5, 20	11)			
	Census Bed Typ				
	SNF/NF:	102			
	Total:	102			
	Census Payor Ty	•			
	Medicare:	15			
	Medicaid:	75			
	Other:	12			
	Total:	102			
	Sample:	21			
	These deficiencies also reflect state				
	findings in accor	rdance with 410 IAC 16.2.			
	Quality review 4/12	2/11 by Suzanne Williams, RN			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VS5Z11

Facility ID:

000012

TITLE

If continuation sheet

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
<b> </b>		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155029	B. WING		04/07/2011		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIER			AST 16TH STREET			
COMMU	INITY NURSING AN	D REHABILITATION CENTER		IAPOLIS, IN46218			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	TAG DEFICIENCY)			
F0157 SS=D	resident; consult wand if known, notif representative or a when there is an a resident which respotential for requir significant change mental, or psychodeterioration in he psychosocial statu conditions or clinicalter treatment sig discontinue an exito adverse consequency form of treatment for the significant of the	is in either life threatening cal complications); a need to nificantly (i.e., a need to sting form of treatment due juences, or to commence a nent); or a decision to					
	The facility must a resident and, if know representative or in when there is a chassignment as speading a change in reside State law or regular paragraph (b)(1) of the facility must resident and the facility must resi	Iso promptly notify the own, the resident's legal interested family member ange in room or roommate ecified in §483.15(e)(2); or ent rights under Federal or ations as specified in of this section.					
	resident's legal rep family member.	s and phone number of the presentative or interested					
	Based on record review and interview, the facility failed to ensure the physician was		F0157	F157 Notify of Changes/Injury/Decline/Room/etc	05/02/2011		
	the parameters of residents with ca notification of a	medication error for 1 of ewed for medication		It is the practice of this provider to ensure that all alleged violations involving the notification of change injury, decline, room change, etc. a accordance with State and Federal What corrective action(s) will be for those residents found to have	re in aw. taken		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VS5Z11

Facility ID:

000012

If continuation sheet

Page 2 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DINC	00	COMPL	ETED
		155029	B. WING			04/07/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			AST 16TH STREET		
COMMU	NITY NI IDQING AN	ID REHABILITATION CENTER			APOLIS, IN46218		
COMMO	INIT T NURSING AN	ID REHABILITATION CENTER		INDIAN	AFOLIS, IN402 18		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	(Residents #6, #	95).			affected by the deficient practice?		
					The MD has been notified of reside	mt #6°	
	Findings include	··			s recent blood glucose readings inc		
	1 1114111.55 111414.4	•			those above call order range. The N		
	1 The man and fo	on Desident #6 wes			was also notified of medication error		
	1. The record for Resident #6 was reviewed on 4/4/11 at 1:15 P.M.				with ferrous sulfate, new orders we		
					obtained and medication error corre		
					action provided to nurse responsible error.	e ior	
	Current diagnoses included, but were not limited to, neuropathic pain, syncope, chest pain, diabetes mellitus, ketoacidosis,				VII 01.		
					How will you identify other reside	ents	
					having the potential to be affected		
	coronary artery disease, and hypertension.				the same deficient practice and w	hat	
					corrective action will be taken?		
	A gurrant haalth	care plan deted 5/11/10			All residents who reside in the facil	itv	
		care plan, dated 5/11/10			have the potential to be affected by	-	
	1	1/20/11, indicated a			alleged deficient practice.		
	1 ^	etes. One intervention			TI CLED I LO II L		
	indicated blood	sugars were to be done as			The Staff Development Coordinato designee will educate facility nurse		
	ordered.				blood glucose monitoring,	3 011	
					documentation and MD notification	ı in	
	A current physic	ian's order, originally			regards to call orders.		
		ndicated accuchecks			CLOSE LANGE LA		
	1	od sugars) were to be done			Staff Development Coordinator or designee will educate nurses on		
	1				medication errors and appropriate		
	1	Iondays and Thursdays,			notification process.		
	1	hysician for blood sugar					
	readings less that	in 70 or greater than 200.			DNS or designee will educate nurse		
					management team on appropriate reprocess.	ewrite	
	The "Capillary F	Blood Glucose Monitoring			p. 000033.		
		ary, 2011, indicated the					
	following blood				What measures will be put into p		
	2/3/11 at 4:00 P.M. BS (blood sugar) 267 2/10/11 at 6:00 A.M. BS 233 2/17/11 at 4:00 P.M. BS 204				or what systemic changes will you	l	
					make to ensure that the deficient practice does not recur?		
					praesice ases not retur.		
					Medication Error CQI will be comp	oleted	
	2/24/11 at 4:00 I	P.M. BS 223			once weekly X 4, biweekly X 2 the	n	
	2/28/11 at 4:00 I	P.M. BS 224			quarterly thereafter.		

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155029	B. WING	-	04/07/	2011		
				ET ADDRESS, CITY, STATE, ZIP COD	<b>_</b> DE			
NAME OF I	PROVIDER OR SUPPLIER		I	EAST 16TH STREET				
COMMU	NITY NURSING AN	D REHABILITATION CENTER	INDIANAPOLIS, IN46218					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APP	JLD BE 'ROPRIATE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	1 *	Blood Glucose Monitoring		Change of condition CQI was completed once weekly X 4				
	Tool" for March,	2011, indicated the		2 then quarterly thereafter.	DIWEERIY A			
	following blood	sugars:		1				
	3/3/11 at 4:00 P.1	M. BS 223						
	3/14/11 at 6:00 A	A.M. BS 223		weekly X 4, biweekly X 2 then quarterly thereafter.				
	3/24/11 at 6:00 A	A.M. BS 237		thereafter.				
				How the corrective action(	s) will be			
	The February and	d March, 2011, MARs		monitored to ensure the de				
		ninistration Records),		practice will not recur, i.e. quality assurance program				
	`	d Capillary Blood		into place?	win be put			
				·				
		ring Tool all lacked		The medication error, chang				
	documentation o			condition and MAR/TAR Coreviewed monthly by the CO				
		hese blood sugars over		Committee.	ži.			
	200.							
				Deficiency in this practice w				
	During the daily	conference on 4/4/11 at		disciplinary action up to and				
	5:00 P.M. with th	ne Administrator and		termination of the responsio	termination of the responsible employee.			
	DON (Director o	of Nursing), information						
	on the missing no	otifications for these						
	blood sugars was	s requested.						
		-						
	During the daily	conference with the						
	Administrator, D							
		on 4/5/11 at 4:25 P.M.,						
	l ` ′	ed no notifications were						
	found.	od no nounoutons were						
		s record was reviewed on						
	04/04/11 at 9:50 A.M., diagnoses included							
	but were not limited to encephalopathy,							
	hypertension, congestive heart failure,							
	Barretts esophagus, right sided CVA and							
	seizures.							
	A physicians ord	er dated 02/09/11						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/07/2011	
NAME OF I	PROVIDER OR SUPPLIEI	<b>"</b> {		ADDRESS, CITY, STATE, ZIP CODE	•
COMMU	NITY NURSING AN	ID REHABILITATION CENTER	l l	EAST 16TH STREET NAPOLIS, IN46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "d/c (or sulfate (iron supper day). Start for (milligrams) soll (gastrostomy tube)  A physicians or or P.M., indicated, sulfate TID start per g-tube daily.  A current Medic Record dated 04 was to receive "I G-tube three time the physicians or Record review in received Ferrous 03/01/11 thru 04/11.	discontinue) ferrous plement) TID (three times prous sulfate 300 mg (solution) per g-tube be) daily."  der dated 04/04/11 at 4:30 "clarification d/c ferrous ferrous sulfate 300 mg "  ation Administration /01/11 indicated resident Ferrous sulf 300 mgs per es daily." Original date of rder was 02/07/11.  adicated Resident #95 s Sulfate TID from /03/11.		CROSS-REFERENCED TO THE APPROPRIA	ATE
	The record lacked documentation regarding physician notification of the medication error.				
	indicated, "order	ed 04/04/11 at 5:30 P.M., clarification rc'd and faxed pharmacy."			
	2:00 P.M., indic	th LPN #2 on 04/05/11 at ated, "the physician in the nurses notes."			
	During exit conf	Ference on 04/05/11 at			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 00 COMPLE  B. WING 04/07/20			ETED	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  5600 EAST 16TH STREET  INDIANAPOLIS, IN46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			Έ	(X5) COMPLETION DATE
F0282 SS=E	indicated the phy notified of the model 3.1-4(a)(3) The services proving facility must be pro-	ded or arranged by the ovided by qualified persons					
	in accordance with each resident's written plan of care.  Based on record review and interview, the facility failed to ensure sliding scale insulin (SSI) was given as ordered for 1 of 2 diabetics with SSI ordered (Resident #32), and to ensure oxygen saturation (O2 Sat) levels were measured as ordered for 1 of 2 residents reviewed for O2 Sat levels (Resident #44), and blood pressures (B/P's) and heart rates (HRs) were taken and antihypertensive medication held as ordered for 4 of 5 residents with orders to monitor B/P and hold medication (Residents #32, #5, #69, #95) and 1 of 2 residents with HR orders (Resident #71) in a sample of 21.  Findings include:		F02	282	F282 Services by qualified person care plan.  It is the practice of this provider to ensure that all alleged violations involving services by qualified persons/per care plan are in accorda with State and Federal law.  What corrective action(s) will be to for those residents found to have the affected by the deficient practice?  MD was notified of Resident #32's recent blood glucose readings and be pressure values.  The MD was notified of resident #4 O2 saturations and no new orders we obtained at this time.  MD was notified of Resident #5's reblood pressure readings. Hold parameters were reviewed with the physician.	raken peen dood 4's	05/02/2011
	reviewed on 4/4/11 at 10:15 A.M.  Current diagnoses included, but were not limited to, Alzheimer's dementia, HTN (hypertension), anemia, diabetes mellitus,				MD was notified of Resident #69's recent blood pressure readings. Hold parameters were reviewed with the physicians.  The facility obtained a blood pressure on		
		·			Resident#95 and notified MD of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155029	A. BUII B. WIN			04/07/20	)11
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R					
0011111		ID DELLA DIL ITATIONI GENITED		1	AST 16TH STREET		
COMMU	NITY NURSING AN	ID REHABILITATION CENTER		INDIAN	APOLIS, IN46218		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	<sub></sub>	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	<u>'</u>	DATE
	osteoporosis, an	d acute renal failure.,			reading. Hold parameters were rev	riewed	
					with the physician.		
	A assumant haalth	same plan, dated 2/17/11					
		care plan, dated 3/17/11		The facility obtained the heart rate for resident #71 and the MD was notified of			
	_	lem of diabetes with an			the reading. Hold parameters were		
	intervention "Ins	sulin/meds (medications)			reviewed with the physicians.		
	as ordered."				1 3		
					How will you identify other resid		
	A current health care plan, dated 3/17/11, indicated a problem of HTN with an intervention of "Antihypertensive				having the potential to be affected		
					the same deficient practice and w	hat	
					corrective action will be taken?		
					All residents who receive medication	ons	
	medication as ordered."				requiring vital sign and blood gluce		
					monitoring with or without hold or		
	A current physic	eian's order, dated 3/4/11,			per MD order have the potential to	be	
	1	as to be administered as			affected by this alleged deficient		
		og (type of insulin) inject			practice.		
					The Staff Development Coordinate	or or	
		eously) for blood sugar			designee will educate facility nurse		
	l ` ′	= 2 units, BS 251 - 300 =			blood glucose and vital sign monitor	oring,	
	3 units, BS 301	-400 = 4 units, and to call			documentation and MD notification	n in	
	the physician if	BS less than 70 or more			regards to call/hold orders.		
	than 400.				The Staff Development Coordinate	or or	
					designee will educate nurses on		
	The March 201	1 MAR (Medication			following physician orders including	ng	
		1, MAR (Medication			vital sign monitoring and documen		
		Record) and March, 2011,			hold orders, call orders and sliding	scale	
	1 ^ -	Glucose Monitoring Tool			insulin administration and		
	indicated:				documentation		
	3/17/11 at 6:00 A	A.M. BS 232 - lacked			What measures will be put into p	lace	
	documentation of	of SSI being given, should			or what systemic changes will you		
	have received 2				make to ensure that the deficient		
					practice does not recur?		
	3/26/11 at 9:00 P.M. BS 322 - lacked documentation of SSI being given, should have received 4 units.				Medication Error CQI will be com	nlatad	
					once weekly X 4, biweekly X 2 the	· I	
					quarterly thereafter.	-	
	A current physic	eian's order, dated 3/4/11,			Change of condition CQI will be		
	1	pril (antihypertensive) 20			completed once weekly X 4, biwee	kly X	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, ріп	LDING	00	COMPLE	ETED	
		155029	B. WIN			04/07/20	)11	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF	PROVIDER OR SUPPLIE	R		1	AST 16TH STREET			
COMMU	NITY NURSING AN	ID REHABILITATION CENTER		1	APOLIS, IN46218			
				L	7.11 02.10, 11.1102.10	(7/5)		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION)	-	TAG			DATE	
	1	was to be given once a			2 then quarterly thereafter.			
	day, but held for	B/P less than 120.			MAR/TAR CQI will be completed			
					weekly X 4, biweekly X 2 then qua			
	The March, 201	1, MAR indicated on			thereafter.			
	3/27/11 a B/P of	£119/76 and on 3/30/11 a			How the connective action(s) will	h.		
	B/P of 119/68.	The MAR did not indicate			How the corrective action(s) will monitored to ensure the deficient			
	the Lisinopril had been held on either of those days.				practice will not recur, i.e. what			
					quality assurance program will b	e put		
	those days.				into place?			
	During the daily conference with the				The medication error, change of			
					condition and MAR/TAR CQI's wi	ll be		
	1	nd DON (Director of			reviewed monthly by the CQI			
	J	/11 at 5:00 P.M.,			Committee.			
	information rega	arding the missing SSI		Deficiency in this practic		ılt in		
	doses and if the	Lisinopril was held was			disciplinary action up to and includ			
	requested.				termination of the responsible emp			
	During the daily	conference with the						
	1 -	OON, and ADON						
	1	) on 4/5/11 at 4:30 P.M.,						
	1 `	ted no information						
	1 "	SI and holding the						
	Lisinopril was fo	ound.						
	l							
		or Resident #44 was						
	reviewed on 4/5	/11 at 10:00 A.M.						
	Current diagnos	es included but were not						
	limited to, osteo	arthritis, COPD (chronic						
	obstructive pulm							
	emphysema, metastatic colon cancer, and neuropathy.							
	A angenerate 1, 1, 1, 1, 1	مرام سام ما م						
	1	care plan, dated						
	12/10/10, indica	ted a problem of COPD						

000012

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155029	B. WIN	G		04/07/20	011
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	AST 16TH STREET		
COMMU	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	IAPOLIS, IN46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		tion of "Monitor oxygen					
	saturation via pu	lse oximeter as ordered."					
	A current physician's order, originally dated 9/2/10, indicated O2 Sats were to be						
	monitored every	Shift.					
	The March, 2011						
	Treatment Flow Sheets lacked						
		f O2 Sat readings on:					
	3/1/11 on day shi	•					
	3/2/11 on evenin						
	3/3/11 on night s	<b>-</b>					
	3/7/11 on highes						
	3/8/11 on evening	•					
	3/11/11 on evening	•					
		vening and night shift					
	l ,	evening, and night shift					
	3/16/11 on eveni	<u> </u>					
		evening, and night shift					
	3/18/11 on day, 0	<u> </u>					
		evening, and night shift					
	3/19/11 on day, 6	_					
	3/25/11 on night	•					
	3/26/11 on day a						
	1	evening, and night shift					
	5/2//11 On day, C	evening, and inglit sillit					
	The February, 20	011, MAR and Nebulizer					
	Treatment Flow						
		f O2 Sat readings on:					
	2//4/11 on evenir	· ·					
		_					
	2/5/11 on day, evening, and night shift 2/7/11 on night shift						
	2/11/11 on eveni						
	2, 11, 11 OH CVCIII	115 011111					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155029		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL <b>04/07/2</b>	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u> S	•		DDRESS, CITY, STATE, ZIP CODE	•	
COMMU	NITY NURSING AN	D REHABILITATION CENTER			AST 16TH STREET APOLIS, IN46218		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION DATE
1710	2/12/11 on night	· · · · · · · · · · · · · · · · · · ·		mo	<u> </u>		DATE
	2/13/11 on day s						
	2/14/11 on eveni						
	2/15/11 on eveni	· ·					
	2/23/11 on eveni						
	2/24/11 on eveni						
		ng and night shift					
	2/26/11 on day, evening and night shift						
	2/27/11 on eveni	ng shift					
	During the daily						
	Administrator, DON, and ADON on						
		M., information regarding					
		Sats was requested.					
	During an interv	iew on 4/6/11 at 12:40					
	P.M., the DON i	ndicated they had only					
		of the missing O2 Sats,					
	· ·	ntified as this as a					
	problem they wo	ould work on.					
		r Resident #5 was					
	reviewed on 4/4/						
	1	es included, but were not					
		ones, pancreatitis, CHF					
	1 ` •	t failure), COPD, atrial					
		ID (arterial sclerotic heart					
	disease) HTN, an	nd diabetes mellitus.					
	A current health	_					
	10/15/10, indicated a problem of elevated B/P, receives antihypertensive						
		erventions included, but					
	were not limited	to, monitor B/P as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029		(X2) MULTIPLE  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  7/2011	
	PROVIDER OR SUPPLIER	L D REHABILITATION CENTER	5600	T ADDRESS, CITY, STATE, ZIP C EAST 16TH STREET ANAPOLIS, IN46218	ODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR ordered and notif meds as ordered A current physic dated 1/17/11, in (antihypertensive mg to be given o	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  fy MD if high or low, and	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE J DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	following SB/Ps: 3/4/11 108 3/12/11 106 3/18/11 104 3/24/11 108	nt indicate the Verapamil				
	Administrator, D 4/4/11 at 5:00 P.I holding the Verap  During the daily Administrator, D 4/5/11 at 4:30 P.I the Verapamil ha 4. Resident #69 on 04/04/11 at 1: included but wer Alzheimers, hype	's record was reviewed 25 P.M., diagnoses				

NAME OF PROVIDER OR SUPPLIER  COMMUNITY NURSING AND REHABILITATION CENTER  SIRRIFAT ADDRESS, CITY, STATIL, JUP CODIC 5600 EAST 16TH STREET  INDIANAPOLIS, IN46218  SUMMAY STATEMENT OF DEFICIENCIES  PREFIX LAG SUMMAY STATEMENT OF DEFICIENCIES  REGULATORY OR LSC IDENTIFYING INFORMATION)  The record review indicated current physicians order originally ordered on 10/17/08, for Lisinopril (blood pressure medication) 20 mg 1 tablet by mouth daily. Hold if SBP (systolic blood pressure) <70.  Record review of the medication administration that resident #69's BP had been checked regularly prior to administration that Lisinopril from 02/01/11 to 04/04/11.  Record review of nursing notes dated 03/09/11 at 8:00 A.M., indicated Resident #69's BP was 102/62.  Record review of nursing notes dated 03/22/11 at 9:00 A.M., indicated Resident #69's BP was 121/66.  Review of the Medication Administration Record (MAR) dated 03/01/11 thru 03/31/11 indicated resident received the Lisinopril on 03/09/11 at 4:20 P.M., he indicated "the daily BP's were not found."  5. Resident #95's record was reviewed on 04/04/11 at 9:50 A.M., diagnoses included but		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLI IDENTIFICATION NUM				NSTRUCTION 00		(X3) DATE COMPL	
STREET ADDRESS, CITY, STATE, ZIP CODE  5600 EAST 16TH STREET  INDIANAPOLIS, INAGE18  INDIANAPOLIS, INAGE18  SUMMARY STATEMENT OF DEFICIENCIES  INDIANAPOLIS, INAGE18  TAG  The record review indicated current physicians order originally ordered on 10/17/08, for Lisinopril (blood pressure medication) 20 mg 1 tablet by mouth daily. Hold if SBP (systolic blood pressure) < 20 or DBP (diastolic blood pressure) < 20 or DBP (diastolic blood pressure)   20 or DBP (diastolic blood pressure)										
Solution   Solution			<u> </u>		B. WINC		DDRESS CITY STA	TE ZIP CODE		
COMMUNITY NURSING AND REHABILITATION CENTER   INDIANAPOLIS, IN46218   IN SUMMARY STATIMENT OF DIRECTIONALS (RACH DEPECTIONAL WAST AS PERCEDED BY FULL REGULATORY OR LOS COMPLETION (RACH DEPECTIONAL WAST AS PERCEDED BY FULL REGULATORY OR LOS COMPLETION (DATE)	NAME OF F	PROVIDER OR SUPPLIEF	2							
REFEX TAG REGULATORY OR LSC IDENTIFYING MORMATION)  The record review indicated current physicians order originally ordered on 10/17/08, for Lisinopril (blood pressure medication) 20 mg 1 tablet by mouth daily. Hold if SBP (systolic blood pressure) <10.  Record review of the medication administration record (MAR) lacked documentation that resident #69's BP had been checked regularly prior to administration of the Lisinopril from 02/01/11 to 04/04/11.  Record review of nursing notes dated 03/09/11 at 8:00 A.M., indicated Resident #69's BP was 102/62.  Record review of nursing notes dated 03/22/11 at 9:00 A.M., indicated Resident #69's BP was 121/66.  Review of the Medication Administration Record (MAR) dated 03/09/11 at 03/09/11 thru 03/31/11 indicated resident received the Lisinopril on 03/09/11 at 4:20 P.M., he indicated "the daily BP's were not found."  5. Resident #95's record was reviewed on 04/04/11 at 9:50 A.M., diagnoses included but	COMMUI	NITY NURSING AN	ID REHABILITATION	N CENTER						
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VS5Z11 Facility ID: 000012 If continuation sheet Page 12 of 28	EODM CMC 2				05744	Engility: 1	D: 000012	If continuation -1	naat D	40 of 00

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
THIS TETRIC	or connection	155029		LDING	<u> </u>	04/07/2	
NAME OF F			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	AST 16TH STREET		
		D REHABILITATION CENTER		INDIAN	APOLIS, IN46218		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
		encephalopathy, hypertension, lure, Barretts esophagus, right ures.					
	The record review indicated current						
ı	physicians order	originally ordered on					
	•	alodipine (blood pressure					
	′ '	g 1 tablet per g-tube e) once daily hold for					
	SBP <120. Take	,					
	administration.	r					
	Record review of						
		cord (MAR) lacked nat Resident #95's BP had					
		or to administration of					
	the Amlodipine f	From 02/09/11 to					
	04/04/11.						
	During an intervi	iew with the Director of					
	_	4/11 at 4:20 P.M., he					
	indicated "the da	ily BP's were not found."					
	6 The record for	r Resident #71 was					
	reviewed on 4/5/						
	_	esident #71 included but					
		to Hypertension, Chronic					
	Renal Insufficien Seizures.	icy, Alicillia, allu					
		ian's order originally					
		licated a need for					
	wietopro101 100 f	milligrams (mg) 1 tablet					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155029	A. BUILDING	00	04/07/2011
		100020	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	1 0 11/2011
NAME OF P	ROVIDER OR SUPPLIER		I	0 EAST 16TH STREET	
		D REHABILITATION CENTER		IANAPOLIS, IN46218	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
		d if the SBP (systolic	1.10		3.112
	_	s less than 100 or the			
	heart rate (HR) is				
	,				
	The February Me	edication Administration			
	Record (MAR) la	acked documentation of			
	any (HR) recorde	ed from February 1 - 10,			
	2011.				
	•	iew on 4/5/11 at 4:30			
		istrator indicated no HR			
	for Resident # 71	10, 2011 could be found			
	101 Kesidelit # / 1	•			
	3.1-35(g)(2)				
	(8)(=)				
E0200	Fach resident mus	at receive and the facility			
F0309 SS=D		st receive and the facility necessary care and services			
30-D	to attain or mainta	in the highest practicable			
		and psychosocial well-being,			
	assessment and p	n the comprehensive plan of care.			
		ew and record review, the	F0309	F309 Provide care/services for h	ighest 05/02/2011
	facility failed to	ensure a resident with an		well being.	
	arterial-venous fi	istula (AV fistula)		It is the practice of this provider to	)
	receiving hemod	ialysis did not receive		ensure that all alleged violations involving providing care/services	for
	_	ections in the same		highest well being are in accordan	
	<u>-</u>	fistula, and failed to		State and Federal law.	
		tula site was properly		What corrective action(s) will be	e taken
	assessed. This affected 1 out of 4 residents			for those residents found to have	e been
		fistulas in a sample of		affected by the deficient practice	7
	21. (Resident #96)			Resident #96's AV fistula site was	
	Findings include			assessed and no abnormal findings noted. The resident's medical reco	
	i mamga merude	•		notes. The resident's medical feet	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155029	B. WIN		<del></del>	04/07/2011
			В. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	-			AST 16TH STREET	
COMMUI	NITY NURSING AN	D REHABILITATION CENTER		I	APOLIS, IN46218	
						(VE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CV MUST BE BEDGEDED BY ELLL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)	+	IAG	was updated with appropriate AV fi	
					site documentation and restrictions	
	A current facility policy provided by the Director of Nursing on 04/06/11 at 8:15					
		•			How will you identify other reside	
	A.M., titled "Dia	lysis Care" dated 03/10,			having the potential to be affected	·
	indicated "an assessment of the resident's dialysis access site will be completed daily to include bruit and thrill (if applicable), condition of skin at site,				the same deficient practice and w corrective action will be taken?	пас
					All residents with AV fistulas and	
					precautions who reside in the facili have the potential to be effected by	- I
		varmth, redness and			alleged deficient practice.	the
	recorded on the N				and general production	
		Record (MAR) and/or			The Staff Development Coordinato	
		, ,			designee will educate facility nurse	
		et specific to facility			appropriate assessment for AV fistu sites and appropriate precautions in	l l
		assessment of the			regards to AV fistula sites.	'
		completed upon return				
	<u>-</u>	is visit to include vital			What measures will be put into p or what systemic changes will you	
	signs and assessr	nent of the site including			l l	
	bruit and thrill (i	f applicable), drainage,			make to ensure that the deficient practice does not recur?	
	and general cond	lition. Documentation of			-	
	the assessment w	vill be recorded on the			Dialysis CQI will be completed on	
	dialysis flow she	et and/or MAR."			weekly X 4, biweekly X 2 then quathereafter.	irterly
	,				increation.	
	   Resident #96's re	ecord was reviewed on			How the corrective action(s) will	be
		P.M., diagnoses included			monitored to ensure the deficient	
					practice will not recur, i.e. what quality assurance program will	
		ited to chronic renal			quanty assurance program win	
	· ·	hypertension, left arm			The dialysis CQI will be reviewed	
	AV fistula, and so	chizophrenia.			monthly by the CQI Committee.	
					Deficiency in this practice will resu	ılt in
	A current care plant	an dated 03/16/11			disciplinary action up to and includ	
	indicated "reside	nt (#96) receives dialysis:			termination of the responsible emp	
	potential for com	plications. Approaches				
	included: assess dialysis shunt q [every] shift, monitor bruit and thrill, no BP [blood pressure] or venipuncture in shunt					
	site."	or companional in bilant				
	SILC.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155029		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL <b>04/07/2</b>	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	AST 16TH STREET APOLIS, IN46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAG	The record lacked assessments of the record lacked any regarding the AV  The MAR dated indicated the resist Humalog (insuling scale: <20 units, 251-300 = units, call MD iffollowing dates, insuling injections 03/08/11, 03/13/103/16/11.  An interview with manager on 04/0 indicated "the fistula site checked.  An interview with 04/07/11 at 1:50	d documentation of any he AV fistula site. The y physician orders fistula site.  03/01/11 thru 03/31/11 dent was to receive he subcutaneous per 100 = 0 units, 201-250 = 1 3 units, 301-350 = 5 <70 or >350. On the resident #96 received in the left arm:		IAU			DAIE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155020		(X2) M A. BUI		ONSTRUCTION  00	(X3) DATE S	ETED	
		155029	B. WIN	G		04/07/2	011
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	•	5600 E	ADDRESS, CITY, STATE, ZIP CODE AST 16TH STREET APOLIS, IN46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DE CAMPANA NA ANA CA CAPANACANA		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
F0334 SS=E	The facility must diprocedures that er (i) Before offering seach resident, or the presentative recent the benefits and programment of the benefits of the immunitation, each legal representative regarding the benefits of the immunitation, unlendically contrained already been immunitation, unlendically contrained already been immunitation, unlendically contrained already been immunitation; and immunitation; and	evelop policies and naure that the influenza immunization, he resident's legal eives education regarding otential side effects of the soffered an influenza ober 1 through March 31 ne immunization is medically the resident has already during this time period; or the resident's legal as the opportunity to refuse medical record includes at indicates, at a minimum, dent or resident's legal as provided education effits and potential side a immunization; and dent either received the ation or did not receive the ation due to medical or refusal.  evelop policies and naure that the pneumococcal hereident, or the resident's refuse receives education effits and potential side unization; soffered a pneumococcal east the immunization is dicated or the resident has unized; or the resident's legal as the opportunity to refuse		TAG	DEFICIENCY	. <del>-</del>	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		A. BUII	A. BUILDING  D. WING		(X3) DATE SURVEY COMPLETED 04/07/2011		
		100029	B. WIN			04/07/2	UII
	PROVIDER OR SUPPLIER NITY NURSING AN	D REHABILITATION CENTER		5600 E	ADDRESS, CITY, STATE, ZIP CODE AST 16TH STREET APOLIS, IN46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the following:  (A) That the resic representative was regarding the bene effects of pneumor (B) That the resic pneumococcal impreceive the pneum to medical contrain (v) As an alternative assessment and precommendation, immunization may following the first primunization, unlead to contraindicated or resident's legal represecond immunization assed on record facility failed to obtained for a propositive for a propositive for 7 of 18 resident to the	ractitioner a second pneumococcal be given after 5 years oneumococcal ess medically the resident or the presentative refuses the ion. review and interview, the ensure a consent was eumococcal vaccine, e vaccine or failed to give sidents who had pneumococcal vaccine, ents in a sample of 21 umococcal vaccines 39, #44, #6, #22, #53 and  : lity policy dated July 08 lent Immunization: wided by the Director of	F0	334	F334 Influenza and Pneumococca Immunizations  It is the practice of this provider to ensure that all alleged violations involving influenza and pneumococimmunizations are in accordance we State and Federal law.  What corrective action(s) will be for those residents found to have affected by the deficient practice. Resident#33 was educated on and offered Pneumococcal vaccine. Ac were taken based on resident's wish the vaccination.  Resident#89 was administered Pneumococcal vaccine.  Resident#44 was educated on and offered Pneumococcal vaccine. Ac were taken based on resident's wish	taken been  tions nes for	05/02/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VS5Z11

Facility ID:

000012

If continuation sheet

Page 18 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPI	LETED
		155029	B. WING			04/07/2	2011
		1	D. WING		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R			AST 16TH STREET		
COMMU	NITY NURSING AN	ID REHABILITATION CENTER			APOLIS, IN46218		
					7.1. 02.10, 11.102.10		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	NCY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	<b>†</b>	R LSC IDENTIFYING INFORMATION)	-	IAG	the vaccination.		DATE
	The facility shal				the vaccination.		
		is of residents. Residents			Resident#6 was administered		
	1	d currently immunized per			Pneumococcal vaccine and approp	riate	
	1	nittee on Immunization			documentation noted.		
	Practices (ACIP	) recommendations,			Resident#22 was educated on and		
	unless medically	contraindicated or			offered Pneumococcal vaccine. A	ctions	
	refused by the resident/family."  2. A current facility policy dated July 08 and titled, "Resident Immunization:				were taken based on residents wish	hes for	
					the vaccination.		
					Resident#53 was educated on and		
					offered Pneumococcal vaccine. A	ctions	
	Influenza Vaccination Pneumococcal				were taken based on residents wish	hes for	
	Polysaccharide Vaccine (PPV) and				the vaccination.		
	provided by the				Resident#84 was educated on and		
	1 ^ *	DON indicated,			offered Pneumococcal vaccine. A	ctions	
	"Policy	7 1 11 1 CC 1		were taken based on residents wishes for			
		shall be offered			the vaccination.		
	1	those residents who have			How will you identify other resid	lents	
	completed a con	sent form "			having the potential to be affected	-	
					the same deficient practice and v		
		or Resident #33 was			corrective action will be taken?		
	reviewed on 4/5	/11 at 10:30 A.M.			All residents have the potential to	be	
					affected by this alleged deficient		
	Diagnoses for R	esident #33 included but			practice.		
	1 -	to, Hypertension,			Resident's and/or resident families	will	
		ılar Disease, Congestive			receive education on influenza and		
	1 *	d Chronic Kidney			pneumococcal immunizations upo	n	
	Disease.	a emome reality			admission.		
					SDC or designee will educate faci	lity	
	The immunizati	on record lacked			staff on documentation and	-	
					administration of influenza and		
		of the resident receiving a			pneumococcal immunizations.		
	pneumonia vacc				ED or designee will educate admis	ssions	
	or the facility of	tain a signed consent.			coordinator on appropriate		
					pneumococcal education and cons	ent.	
	4. The record for	or Resident #89 was			What measures will be not inte-	Naga	
	reviewed on 4/4	/11 at 1:30 P.M.			What measures will be put into p	ласе	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155029	B. WIN			04/07/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	AST 16TH STREET		
COMMU	NITV NI IDQING AN	D REHABILITATION CENTER		1	APOLIS, IN46218		
	NITT NORSING AN	D REHABIEITATION CENTER		INDIAN	AI OLIO, III402 IO		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					or what systemic changes will you	ı	
	Diagnoses for Resident #89 included but were not limited to, Chronic Renal				make to ensure that the deficient practice does not recur?		
					practice does not recur:		
	Insufficiency, Di	·			Each new admission will be reviewe	ed by	
	Obstructive Puln				IDT team, consents will be verified		
		•			vaccinations will be administered a	nd	
	Kespiratory Faili	ure and Hypertension.			documented per resident choice.		
					Annually each fall, Staff Developm	ant	
	The immunization	on record indicated the			Coordinator will provide education		
	resident had con	sented to the pneumo			obtain consent forms on all residen		
		ed documentation of the			who reside in the facility. Vaccinati		
		g a pneumonia vaccine.			will be administered and document	ed per	
	Testuciit Teeerviii	g a pheumoma vaceme.			residents' choice.		
	5				Infection control review CQI's will	he	
	"	iew on 4/5/11 at 4:30			completed on a weekly basis x 4,	С	
	P.M., the DON i	ndicated Resident #33,			biweekly x 2, and quarterly thereaf	ter.	
	#89, #44, #6, #22	2, #53 & #84 had not					
	been given the p	neumonia vaccine.			How the corrective action(s) will		
					monitored to ensure the deficient		
					practice will not recur, i.e. what quality assurance program will b		
					into place?	շ բաւ	
					<b>,</b>		
					The CQI committee will review inf control CQI's in the monthly CQI	ection	
					meeting.		
					Deficiency in this practice will resu		
					disciplinary action up to and includ		
		D: 1 // / /			termination of the responsible empl	oyee.	
		or Resident #44 was					
	reviewed on 4/5/	'11 at 10:00 A.M.					
	Current diagnose	es included but were not					
	limited to, osteoa	arthritis, COPD (chronic					
	obstructive pulm						
	· •	· /·					
	empnysema, met	tastatic colon cancer, and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155029		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/07/2011	
NAME OF I	PROVIDER OR SUPPLIEF	<u>"</u>		ADDRESS, CITY, STATE, ZIP CODE	!
COMMU	NITY NURSING AN	D REHABILITATION CENTER		AST 16TH STREET IAPOLIS, IN46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	neuropathy.				
	physician's order pneumonia vacc  The record for R documentation or	recapitulation of rs indicated "may have ine".  esident #44 lacked f a signed consent form of the pneumococcal			
	Administrator, E Nursing), and Al 4/5/11 at 4:30 P.	conference with the DON (Director of DON (Assistant DON) on M., information about neumonia vaccine was			
	6. The record for reviewed on 4/4/	r Resident #6 was /11 at 1:15 P.M.			
	limited to, shorti neuropathic pain mellitus ketoacid	, chest pain, diabetes			
	_	sent for the administration occal vaccine was dated			
		esident #6 lacked f the pneumococcal			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155029	A. BUII B. WIN			04/07/2	
NAME OF F	PROVIDER OR SUPPLIER		D. WIW		ADDRESS, CITY, STATE, ZIP CODE		
					AST 16TH STREET		
		D REHABILITATION CENTER			APOLIS, IN46218		(15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	vaccine being ad	ministered.					
	During the daily Administrator, D Nursing), and AE 4/4/11 at 5:00 P.N Resident #6's pnorequested.  7. The record for reviewed on 4/5/ Current diagnose limited to, hypert mellitus, schizop renal failure, and The April, 2011, physician's order pneumonia vacci The record for Redocumentation of being offered, co administration.  During the daily Administrator, D Nursing), and AE 4/5/11 at 4:30 P.N	conference with the ON (Director of DON (Assistant DON) on M., information about eumonia vaccine was  r Resident #22 was 11 at 3:35 P.M.  es included, but were not tension (HTN), diabetes hrenia, arthritis, chronic a seizure disorder.  recapitulation of s indicated "may have ne".  esident #22 lacked f pneumococcal vaccine insent signed, or					
	requested.						
	8. The record for	r Resident #53 was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155029	B. WIN			04/07/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					AST 16TH STREET	
COMMUI	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	APOLIS, IN46218	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	DATE
	reviewed on 4/5/	11 at 2:20 P.M.				
	G 1:					
	_	es included, but were not				
		ticus, stroke, borderline				
	personality disor					
	schizophrenia, ar	nd diabetes mellitus.				
	TT1 11 1	1				
	The record lacke					
		f the pneumococcal				
	vaccine.					
	D : 41 1:1	6				
		conference with the				
	Administrator, D	,				
	• • • • • • • • • • • • • • • • • • • •	OON (Assistant DON) on				
		M., information about				
	_	neumonia vaccine was				
	requested.					
		s record was reviewed on				
		P.M., diagnoses included				
	but were not limi	•				
	schizophrenia, hy	• •				
	hypertension, and					
	extremity edema	•				
		1.1				
		d documentation of a				
	•	neumonia vaccine or of				
		eiving or declining the				
	pneumonia vacci	ne.				
	2.1.12(.)					
	3.1-13(a)					
			l			I I

000012

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY  COMPLETED		
		155029	B. WIN	G		04/07/2	011
	PROVIDER OR SUPPLIER NITY NURSING ANI	D REHABILITATION CENTER		5600 EA	ADDRESS, CITY, STATE, ZIP CODE AST 16TH STREET APOLIS, IN46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0371 SS=E	considered satisfar local authorities; a (2) Store, prepare, under sanitary con Based on record the facility failed washed their hand policy for 1 of 2. This had the poteresidents who attended to 102 residents in Findings include:  A current facility and titled, "Hand by the Dietary M. A.M. indicated, "Policy Dietary staff will handling soiled sutensils before food-contact surf engaging in other contaminate hand.  During the kitches service on 4/4/11 was observed scoresident's plates. scooping the sour The cook removed.	distribute and serve food diditions review and observation to ensure kitchen staff ds according to facility kitchen observations. Ential to affect 92 emeals from the kitchen residing in the facility.  policy updated on 05/06 Washing" and provided anager on 4/5/11 at 10:55  wash hands after urfaces, equipment or touching food or faces; and after activities that	F0	371	F371 Food procure, store/prepare/serve-sanitary.  It is the practice of this provider to ensure that all alleged violations involving the food procurement, storage/preparation/serve-sanitation in accordance with State and Federalaw.  What corrective action(s) will be to for those residents found to have affected by the deficient practice?  A list of residents affected by allege deficient practice was not provided.  Cook#1 was educated on appropriate hand washing and handling of dishe utensils.  How will you identify other reside having the potential to be affected the same deficient practice and we corrective action will be taken?  All residents who reside in the facil have the potential to be affected by alleged deficient practice.  The Dietary Manager or designee we educate dietary staff on hand washin and appropriate food, dish and uten handling and serving.  What measures will be put into plor what systemic changes will you make to ensure that the deficient practice does not recur?	taken been  ed te es and l by hat ity this	05/02/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00			(X3) DATE SURVEY COMPLETED			
155029		A. BUILD			04/07/2			
100020			B. WING		DDDESS CITY STATE ZID CODE	0 170172		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  5600 EAST 16TH STREET					
COMMUNITY NURSING AND REHABILITATION CENTER			INDIANAPOLIS, IN46218					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE	
		the ladle under running			Dietary CQI will be completed once			
		ed the ladle to another			weekly X 4, biweekly X 2 then quan			
	-	ash and sanitize and the the service line. No hand			thereafter.			
		erved. Cook #1 picked			How the corrective action(s) will b	oe		
	_	o inside the bowl and		monitored to ensure the deficien practice will not recur, i.e. what				
	-	beans. She then picked			quality assurance program will be			
		nb over the edge of the			into place?			
		resident's potatoes and			The dietary CQI will be reviewed			
	• •	e plate. Cook #1 turned			monthly by the CQI Committee.			
		ervice line and opened a			Deficiency in this practice will resu	lt in		
	-	e another ladle, and			disciplinary action up to and includi			
	returned to the se	ervice line without			termination of the responsible emple	oyee.		
	washing her hand	ds. She continued to pick						
	up bowls and pla	tes with the thumb inside						
	the bowl and cov	vering the edge of the						
	plates while scoo	pping the resident's food.						
	•	around to retrieve						
	another ladle from	m the drawer, walked to						
		down the burner and						
	*	green beans. Cook # 1						
		ervice line and continued						
	-	inside the bowls and						
		es of the plates without						
	washing her hand	ds.						
	3.1-21(i)(3)							
F0502	The facility must n	rovide or obtain laboratory		l				
SS=D	services to meet the	ne needs of its residents.						
		onsible for the quality and						
	timeliness of the se	ervices.  ew and record review, the	F05	02	F502 Provide/obtain laboratory		05/02/2011	
		ensure laboratory orders	103	02	SVC-quality/timely.		03/02/2011	
	racinty ranted to t	chouse laboratory orders						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155029		A. BUIL			(X3) DATE COMPL 04/07/2	ETED	
100020			B. WINC		DDRESS, CITY, STATE, ZIP CODE	04/01/12	
NAME OF PROVIDER OR SUPPLIER					AST 16TH STREET		
COMMUNITY NURSING AND REHABILITATION CENTER			INDIANAPOLIS, IN46218				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		vere followed. This		IAG			DAIL
	J 1 J				It is the practice of this provider to		
	affected 1 out of 21 residents reviewed for laboratory orders in a sample of 21. (Resident #84)				ensure that all alleged violations involving Providing/obtaining labo	ratory	
					SVC-quality/timely are in accordar with State and Federal law.		
					with State and rederal law.		
	Findings include:				What corrective action(s) will be for those residents found to have		
Resident #84's rec		ecord was reviewed on			affected by the deficient practice?		
	04/05/11 at 1:20	P.M., diagnoses included			Lab ordered for Resident #84 has b	een	
	but were not limited to paranoid				obtained and the MD was notified of		
	schizophrenia, h	yperlipidemia,			results.		
	hypertension, and bilateral lower extremity edema.  The record review indicated a current				How will you identify other residents		
					having the potential to be affected the same deficient practice and w		
					corrective action will be taken?		
					AH 11 / 1 1 1 1		
	* *	dated 02/24/11 for a		All residents who receive laborate services who reside in the facility			
	BMP (Basal Metabolic Panel lab) every				the potential to be effected by the alleged		
	six months begin	nning in March 2011.			deficient practice.		
	The record lacked documentation of the lab being drawn.  An interview with the Director of Nursing on 04/06/11 at 4:30 P.M., indicated there				All residents receiving laboratory		
					services were reviewed to assure they were receiving laboratory services per		
					MD order.	•	
					The Staff Development Coordinato	or or	
					designee will educate facility nurses on		
	was no further de	ocumentation regarding			following MD orders for laboratory services and facility based lab proc		
	the lab.						
					What measures will be put into poor what systemic changes will you		
	3.1-49(a)				make to ensure that the deficient		
					practice does not recur?		
					Labs/diagnostics CQI will be comp	leted	
					once weekly X 4, biweekly X 2 the quarterly thereafter.		
					quarterly increation.		
					How the corrective action(s) will	be	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SU	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
155029		155029	B. WING		·	04/07/20	11	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			5600 EAST 16TH STREET					
COMMUNITY NURSING AND REHABILITATION CENTER			INDIANAPOLIS, IN46218					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)		ГЕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE	
					monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will			
					The labs/diagnostics CQI will be reviewed monthly by the CQI Committee.			
F0504	The facility must b	rovide or obtain laboratory			Deficiency in this practice will resu disciplinary action up to and includ termination of the responsible empl	ing		
F0504 SS=D		n ordered by the attending						
00 5	physician.	, ,						
	Based on record	review and interview, the	F0	504	F504 Lab SVCS only when	.	05/02/2011	
	facility failed to	ensure laboratory (lab)			ordered by physician. It is to practice of this provider to er			
	blood work was i	not done without a			that all alleged violations invo			
	physician's order	for the lab work for 1 of			Providing/obtaining laborator	- 1		
	18 residents revie	ewed for lab blood work			SVCS only when ordered by			
	in a sample of 21	(resident #6).			physician are in accordance State and Federal law. <b>What</b>			
	Findings include	:			corrective action(s) will be taken for those residents fo to have been affected by th	· · · · · · · · · · · · · · · · · · ·		
	The record for Ro	esident #6 was reviewed			deficient practice? The BMF			
	on 4/4/11 at 1:15	P.M.			draw was d/c'd for Resident			
					lab was notified and the resid			
	Current diagnose	s included, but were not			no longer receives this laborate service. <b>How will you ident</b>	- 1		
	limited to, shortn				other residents having the	,		
	· ·	, chest pain, diabetes			potential to be affected by t	he		
	mellitus ketoacid	* '			same deficient practice and			
		zures, and coronary			what corrective action will I	I .		
	artery disease.	201 00, min 001011mi y			taken? All residents who rec			
	artery arsouse.				laboratory services who reside the facility have the potential			
	A nhysician's ord	ler, dated 3/8 or 9/11,			effected by the alleged defici			
	1 2	BMP (Basic Metabolic			practice. All residents receiv	ring		
	Panel) was to be	`			laboratory services were revi			
	i alici) was to be	uiscontinucu.			to assure they were receiving	9		
					laboratory services per MD			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	(X2) MU  A. BUILI  B. WING	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/07/2011	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  5600 EAST 16TH STREET  INDIANAPOLIS, IN46218				
	SUMMARY S (EACH DEFICIEN REGULATORY OR  The record conta dated 3/14/11 and  During the daily Administrator, D Nursing), and nu P.M., information draws was requen	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ined BMP lab results d 3/21/11.  conference with the ON (Director of rse consultant at 5:00 n about the BMP blood sted.  e final exit conference on M., no further		STREET A	AST 16TH STREET	nt  ratory ab ill  I will 44,  ive to be lity be lists arry	